Clear Choice Design Committee

Comments from Maine Association of Health Underwriters

September 25, 2020

Plan Design:

Overall, we agree with the approach of using coinsurance in most of the designs instead of copay and limiting the pre-deductible benefits. In any new market offering such as this, the focus needs to be on year three pricing as much or more than the initial pricing. While there is some information available to make judgements on the distribution of members among the plans, much of the pricing for year one will be based on assumptions about member behavior when faced with new plan designs. A merger of the individual and group markets will increase the reliance on assumptions as opposed to historical claim patterns. Year two will have a minimal amount of claim information available when rates need to be submitted. That data is certainly not credible but is directional at best and skewed by high cost claimants at worst. Again, assumptions need to be made around member distribution among the options. Year three will have credible data from year one, assuming no major changes in plan choice by the members. This is the year when corrections to initial pricing assumptions are done since the carriers now have credible data. It's important to avoid a big spike in pricing in year three since that will undoubtedly result in members changing options and impacting the pricing. Although it's not a major influence, coinsurance does not leverage price inflation like copays do which helps moderate price changes.

Plan Options:

We feel that limiting and standardizing options in the Individual market will help the members make rational decisions. Giving the carriers the opportunity to offer three additional options will help with the level of satisfaction of the members since it allows the member to have some say in what their benefits are instead of having it forced upon them as a single option would do. Experience has shown that when the member feels they have a say in what their benefits are, they are more satisfied with their plan.

In the Shop, the purchasers tend to be more educated about plan designs and usually have a broker as an advisor. Therefore, more than three options per metal level in the Group market would not be detrimental and we would encourage the Bureau to consider that. Also, one suggestion would be to gradually phase in the Clear Choice designs rather than move everybody to the standardized plans in year one, giving the employers time to educate their workforce.

An HSA option at the Silver level would be advantageous since many employers help fund the HSA, so the employee doesn't have such a big deductible to pay on their own. The deductibles are more reasonable at the Silver level making it more manageable for employer and employee.

The prescription benefits are well designed, and we would encourage the Bureau to maintain coinsurance at Tier 3 and Tier 4. We realize that Tier 4 drugs are costly but moving to copays will significantly impact the premium for most members who are using Generics or Preferred Brand drugs. Generic Dispensing Rates (GDR) are in the 80% range or higher. We have clients who exceed 90% so while there may be calls for copays in the Tier 3 and 4 categories, we think they should stay at coinsurance for the sake of lower premiums for the majority of members. Options which limit the member coinsurance to a specific dollar amount (e.g., 50% to a maximum of $500 per script) have been used in some areas but that requires adjustment to the pricing of the plan's OOP maximum so the impact to premiums is still fairly significant.

Final Comment: As stated in the beginning of our comments, the first three years of a new product in a market are critical. Therefore, we feel that if adjustments are to be made to initial plan designs, they should wait until at least Plan Year 4 so that carriers have credible data in which to evaluate any changes.